COLUMBIA RIVER HEALTH

PO Box 397 ● 450 Tatone Street, Boardman, OR 97818 ● 541-481-7212 ● www.crhclinic.net

Date Issued: _____
Returned: _____

SLIDING FEE DISCOUNT PROGRAM FORM

INSTRUCTIONS

If you need help filling out this application we can assist you. If you would like assistance with the Oregon Medicaid application process or the Insurance Marketplace, please ask to meet with our Insurance & Enrollment Specialist. You will receive notification of your sliding scale program qualification by mail.

- Fill out Part A, B, C, & F of the application.
- Provide Proof of Income for all your household members: acceptable documents are any one of the following:
    1) LAST TWO MONTHS PAY STUBS
    2) LAST YEAR'S INCOME TAX FORMS
    3) W-2 FORMS
    4) BANK STATEMENT, IF DIRECT DEPOSIT (i.e. unemployment comp., SSID)
- If you do not have proof of income: Also, fill out Part D & E. A personal interview may be required.
- If Self-employed, provide most recent income tax forms.
- All adults in the household must sign Part F.
- Application must be completed and returned within two weeks of date issued.

-Incomplete applications will be returned, unprocessed.

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*** OFFICE USE ONLY ***	
Effective Date	
Level	
SSF Bracket	
Language	□ English □ Spanish
Processed by	
Name:	

PART A DEMOGRAPHICS

Head of Household Name: _____ Social Security # (optional):_____

Mailing Address: _____ City: _____ State: _____ Zip:_____

Phone #: _____ Cell #:_____ Work #:_____

Message Name/Phone # (optional): _____

Employer's Name & Address:_____ Occupation: _____

Spouse/Partner's Name: _____ Social Security # (optional):_____

Phone #: _____ Cell #:_____ Work #:_____

Employer's Name & Address:_____ Occupation: _____

PART B HOUSEHOLD SIZE

Household Size: Please list all household members, for whom you are financially responsible. List yourself first and your spouse/partner (if applicable) second, then all other household members.

NAME (First, MI, Last)	**Date of Birth**	**Relation to you**	**Patient** (Y/N)	**Living in your home?** (Y/N)
		Self		
		Spouse/ Partner		

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PART C INCOME

Do you own any rental property? Yes ☐ No ☐

List monthly income for all of your household members. Provide proof of income. If you do not have proof of income, please also complete Part D & E.

Wages/Earnings	$	Unemployment	$
Rental Income	$	Pension	$
TANF	$	Social Security	$
Food Stamps	$	Other:	$

PART D INCOME DECLARATION

Fill out only if you cannot provide proof of income

I certify that my total household income for the past three months was $ _____. I further certify that I am unable to supply proof of my total household income due to the following reason(s): _____

_____

_____

I understand that I may qualify for the Sliding Scale Discount Program (in accordance with federal guidelines), for a limited time period. If my total household income and/or the number of household members should change, I understand I must reapply.

PART E SUPPORT INFORMATION

Fill out only if you cannot provide proof of income

1. How are you able to pay for your rent/mortgage? _____
   _____
2. How are you able to pay for your utilities (sewer, garbage, water, phone, electricity, etc.)?_____
   _____
3. How are you able to purchase food? _____
   _____
4. How would you pay for your medical and prescription services? _____
   _____
5. In summary, please describe your current living situation, and how it is that you are able to live and sustain. Indicate if you are receiving any aid or assistance from family, friends, government agencies, or any other person or agency. _____
   _____
   _____
   _____

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PART F VERIFICATION STATEMENT

I certify all information on this form is complete, true, and correct and hereby authorize Columbia River Health (CRH) to verify this information. I have read, and understand, this agreement to be considered valid. A photo copy of such shall have validity as the original. I also understand that if there are any changes in my circumstances I must notify Columbia River Health immediately. All information on this form will remain confidential. I declare under penalty of perjury that all statements contained in this application and any accompanying documents are true and correct, with full knowledge that all statements made in this application are subject to investigation and that any false or dishonest answer to any question may be grounds for denial or subsequent revocation of my application. All adults must sign below to acknowledge they agree with the above verification statement.

Head of Household Signature	Date	Spouse/Partner Signature	Date
Adult Signature	Date	Adult Signature	Date
Adult Signature	Date	Adult Signature	Date

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*Additional Information/Notes **Office Use Only****

Date		CRH Staff Name	
Patient Name		DOB	
Notes			
Date		CRH Staff Name	
Notes			
Date		CRH Staff Name	
Notes			